



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C.L. "BUTCH" OTTER – Governor
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October 16, 2007

R. Wayde Sondrup
Legacy Home Health Care
680 South Progress Avenue Suite 2A
Meridian, Idaho 83642


Dear Mr. Sondrup:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility, Legacy Home Health Care, on October 12, 2007.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208)334-6626.

Sincerely,


RAE JEAN MCPHILLIPS
Health Facility Surveyor
Non-Long Term Care


SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

RJM/mlw

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/12/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 137106	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/12/2007
NAME OF PROVIDER OR SUPPLIER LEGACY HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 680 SOUTH PROGRESS SUITE 2A MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
G 000	<p>INITIAL COMMENTS</p> <p>No deficiencies were cited during the Medicare recertification survey of your Home Health Agency. Legacy Home Care is in compliance with the requirements of 42 CFR Part 484, Conditions of Participation for Home Health Agencies. The surveyors conducting the Medicare certification survey were:</p> <p>Rae Jean McPhillips, RN, HFS, Team Leader Patricia O'Hara, RN, HFS</p>	G 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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N 000	<p>16.03.07 INITIAL COMMENTS</p> <p>No deficiencies were cited during the State licensure survey of your Home Health Agency. Legacy Home Care is in compliance with the requirements of IDAPA 16.03.07, Rules for Home Health Agencies. The surveyors conducting the State licensure survey were:</p> <p>Rae Jean McPhillips, RN, HFS, Team Leader Patricia O'Hara, RN. HFS</p>	N 000		

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE